STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155567	A. BUILDING 00 B. WING	03/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSITY PARK HEALTH AND REHABILITATION CENTER	1400 MEDICAL PARK DR FORT WAYNE, IN 46825

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F0000	This visit was for a Recertification and State Licensure Survey. Survey dates: March 26, 27, 28, 29 & 30, 2012 Facility number: 000459 Provider number: 155567 AIM number: 100289700 Survey team: Angela Strass RN TC Sue Brooker RD Rick Blain RN Diane Nilson RN Census bed type: SNF: 4 SNF/NF: 78 Total: 82 Census payor type: Medicare: 7 Medicaid: 49 Other: 26 Total: 82 These state findings are cited in accordance with 410 IAC 16.2. Quality review completed 4/3/12 Cathy Emswiller RN	F0000	**The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and request a post certification review on or after 04/29/2012.**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F0157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on record review and interview, the facility failed to notify the physician when a resident refused to have lab work done, a prothrombin time/international normalization ratio,	F0157	**F 157 – Notify of changes** It is the practice of this provider to immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an	04/29/2012

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	for 1 of 47 residents reviewed who met the criteria for physician notification. (resident #91) Finding includes: Review of the clinical record on 3/28/12 at 9:30 a.m. for resident #91 indicated she was admitted to the facility on 6/15/11 with diagnoses including but not limited to Encephalitis, Seizures, Benign Hypertension and Cardiomyopathy. The resident also had short term and long term memory problems. Review of nursing notes dated 2/17/12 at 7:30 a.m. indicated "Resident refused to have PT/INR (prothrombin time/international normalized ratio) drawn, became physical, tried to bite staff." On 3/28/12 at 10:00 a.m. review of Resident #91's medication administration record indicated an order dated 2/10/12 for coumadin (a blood thinner) 7 milligrams per mouth daily and to recheck PT/INR in 1 week. There were no further nursing notes related to the residents refusal until documentation on 2/23/12 at 9:00 p.m. which indicated, "No s/s (signs of		interested family member when there is a significant change in the resident's physical, mental, or psychosocial status. **What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice:** Resident 91's physician was notified of the resident's refusal and critical PT/INR on 2/23/2012. A physician's order was obtained to hold the resident's Coumadin and recheck the PT/INR daily until the INR level was below 2.8. No other residents were affected by this finding. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** Residents with orders for PT/INR monitoring have the potential to be affected. A facility wide audit was completed to ensure all residents receiving PT/INR levels been completed and MD notified of results and/or refusals. No other resident were affected. The nurse management team will completed this audit. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** A mandatory nursing in-service will be conducted. This in-service will include review of the facility policy	

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	symptoms of bleeding or bruising." On 3/28/12 at 1:30 p.m. interview with the Administrator and Director of Nursing indicated the resident had refused the PT/INR blood draw and nursing staff had not contacted the physician for new orders. Review of the facility incident documentation dated 2/23/12 indicated that at approximately 4:00 p.m. the DON was notified by the unit manager that Resident #9's PT/INR lab result was a critical level with the INR of 8. The resident's physician was notified and an order was obtained to hold the resident's Coumadin (blood thinner) and recheck the PT/INR daily until the INR level was below 2.8. On 3/29/12 at 1:00 p.m. review of the facility policy "Change in Condition: When to report to the MD/NP/PA" (Medical Doctor/ Nurse Practitioner/Physicians Assistant) indicated to report immediately any new symptoms OR involving a cardiac, psychotropic, or other drug with potential for significant toxic side effects." 3.1-5(a)(2) 3.1-5(a)(3)		titled, "Change in Condition: When to report to the MD/NP/PA". The DON/DSD and/or designee will be responsible for conducting the in-service. **How will the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place:** To ensure ongoing compliance with this corrective action, the DON/designee will be responsible for completion of a PT/INR audit tool titled, "Anti-Coagulant Audit Log" daily x 3 weeks, then 3 times a week for 3 weeks and then weekly thereafter. Findings will be submitted to the QA & A committee for review and follow up. **By what date the systemic changes will be completed:** Compliance Date = 04/29/2012 **Addendum Request: Findings will be submitted to the QA & A committee for review and follow up times 6 months with a subsequent plan developed and implemented as necessary.**	

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F0282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interview and record review, the facility failed to follow physician's orders for fluid restriction for 1 of 1 resident reviewed who met the criteria for dialysis (Resident #125). Findings include: Review of the clinical record of Resident #125 on 3/28/12 at 10:14 a.m., indicated the following: diagnoses included, but were not limited to, hypertension, acute renal failure, GERD (gastroesophageal reflux disease), history of pulmonary embolism, and multiple myeloma. A physician's order for Resident #125, dated for the month of March, 2012, indicated hemodialysis three times a week on Monday, Wednesday, and Friday, and to monitor for signs and symptoms of fluid overload. The physician's order also indicated a 1200 cc (cubic centimeters) fluid restriction, with dietary to give 720 cc daily and nursing to give 330 cc on	F0282	**F 282 – Services by qualified persons/per care plan.** It is the practice of this provider that services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The resident's fluid restriction order was clarified by the physician to 1500cc per day. The current physician order reads dietary to give 720 cc and nursing to give 780 cc which equals 1500 cc per day. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** Residents with a current fluid restriction physician order have the potential to be affected by this finding. A facility wide audit will be conducted to identify other residents with fluid restriction physician orders to ensure total values match the physician order. The nurse management team will be responsible for completing this audit.	04/29/2012

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	the 7a-3p shift, 330 cc on the 3p-11p shift, and 120 cc on the 11p-7a shift. A physician telephone order for Resident #125, dated 3/13/12, indicated a 1200 ml (milliliter) fluid restriction; dietary to give 720 ml daily, nursing to give 330 ml on the 7a-3p- shift, 330 ml on the 3p-11p shift, and 120 ml on the 11p-7a- shift. Calculations of the fluid provided by dietary and each nursing shift indicated she would receive 1500 cc's instead of the 1200 cc's as ordered. The Medication Administration Record for Resident #125, for the month of March, 2012, indicated nursing provided Resident #125 with 330 cc on the 7a-3p shift, 330 cc on the 3p-11p shift, and 120 cc on the 11p-7a shift, a total of 780 cc's over the 3 shifts. A current tray card for Resident #125, provided by the Certified Dietary Manager on 3/29/12 at 9:15 a.m., indicated Resident #125 received a total of 720 cc's of fluid per day from dietary. Combined with the 780 cc total from nursing and the 720 cc's from dietary, Resident #125 received a total of 1500 cc's total over the period of 24 hours. A facility care plan for Resident #125, dated 3/9/12, indicated the problem		**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** A mandatory nursing in-service will be conducted. This in-service will include review of following physicians orders and the facility policy y for monitoring resident's intake with fluid restriction. The DON/DSD and/or designee will be responsible for conducting the in-service. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place:** To ensure ongoing compliance with this corrective action I/O record will be reviewed by the DON/designee daily x 2 weeks, 3 times a week x 2 weeks, 1 time a week x 2 weeks and then monthly thereafter. Further more physician orders will be reviewed during the facility Department Manager meeting. Findings will be submitted to the QA & A committee for review and follow up. **By what date the systemic changes will be completed:** Compliance Date = 04/29/2012 **Addendum Request: Findings will be submitted to the QA & A committee for review and follow up times 6 months with a subsequent plan developed and implemented as necessary.**	

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	area of hemodialysis related to acute renal failure and infection at the access site and subcutaneous access port. Interventions to this problem included, but were not limited to, dialysis on Monday, Wednesday, and Friday, diet as ordered, and fluid restriction of 1200 cc in 24 hours. A facility care plan for Resident #125, dated 3/9/12, indicated the problem area of at risk for fluid overload related to acute renal failure and dialysis. Interventions to the problem included, but were not limited to, monitor fluid intakes to ensure fluid intake does not exceed 1200 cc daily and monitor for signs and symptoms of fluid overload. The Director of Nursing was interviewed on 3/28/12 at 11:15 a.m. During the interview she indicated Resident #125's fluid restriction was 1200 cc's per 24 hours. LPN #2 was interviewed on 3/20/12 at 10:00 a.m. During the interview she indicated Resident #125 was on a 1200 cc fluid restriction. 3.1-35(g)(2)			

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F0354 SS=F	483.30(b) WAIVER-RN 8 HRS 7 DAYS/WK, FULL-TIME DON Except when waived under paragraph (c) or (d) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. Except when waived under paragraph (c) or (d) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. Based on interview and record review, the facility failed to ensure a Registered Nurse was on duty 8 hours daily for 9 of 91 days reviewed. This had the potential to effect 82 of 82 residents who resided in the building. Finding includes: Review of facility staffing schedules on 3/30/12 at 10:15 a.m. indicated the following days which did not have a Registered Nurse working in the building for the months of January, February and March, 2012. January 22, 2012 January 28, 2012 January 29, 2012 February 5, 2012	F0354	**F 354 – Waiver-RN 8 hours 7 days a week, Full time DON.** It is the practice of this provider to use the services of a registered nurse of at least 8 consecutive hours a day, 7 days a week. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** No resident were found to be affected by this alleged deficient practice. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by this finding. The facility has employed a registered nurse to work Saturday and Sunday to ensure 7 day week coverage.	04/29/2012

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	February 11, 2012 February 12, 2012 February 18, 2012 March 3, 2012 March 11, 2012 On 3/30/12 at 10:30 a.m. interview with the Director of Nursing indicated she had a Registered Nurse who had recently resigned. She indicated she comes in on the weekends, but did not have documentation of the days and hours she was in the building. 3.1-17(b)(3)		**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The facility will employ a registered nurse for 8 consecutive hours a day, 7 days a week. **How will the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place:** To ensure ongoing compliance with this corrective action, the Executive Director/designee will review the nursing schedule daily to determine facility need of registered nurse for 8 consecutive hours a day, 7 days a week. Salaried RN managers will sign in and out on daily staffing sheets on weekends. **By what date the systemic changes will be completed:** Compliance Date = 04/29/2012 **Addendum Request: Findings will be submitted to the QA & A committee for review and follow up times 6 months with a subsequent plan developed and implemented as necessary.**	

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F0363 SS=E	483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. Based on observation, interview and record review, the facility failed to provide a nutritionally adequate meal to 18 of 19 residents (Residents #74, #64, #70, #24, #7, #39, #85, #26, #40, #76, #17, #41, #73, #107, #34, #95, #75, and #80) who reside in the Memory Care Unit. Findings include: The menu for the lunch meal on 3/29/12 indicated residents on a Regular Diet received a 3 ounce serving of beef tips , one-half cup of buttered noodles, one-half cup of Italian vegetables blend, 1 slice of bread, one half cup of peaches, and beverages. During an observation of the lunch meal on 3/29/12 at 11:15 a.m., Residents #74, #64, #70, #24, #7, #39, #85, #26, #40, #76, #17, #41, #73, #107, #34, #95, #75, and #80 were seated in the Memory Care dining room waiting for lunch. LPN	F0363	**F 363 – Menus meet resident needs and preparation in advanced and followed.** It is the practice of this provider that menus meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Residents 74,64,70,24,7,39,85,26,40,76,17,41, 73,107,34,95,75, and 80 did not experience any negative outcome as result of this finding. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** The identified staff member, Nurse 1, was thoroughly in-serviced/re-educated regarding the use of the therapeutic spread sheet that indicates the recommended portion sizes. The	04/29/2012

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	#1 was observed serving plates for the residents on the Memory Care Unit. Instead of using the 6 ounce ladle, which was provided for the beef tips au jus, LPN #1 was observed to use the tongs, which had been provided to serve the bread, to serve the beef tips au jus. He was observed to use the tongs twice per plate to pick up small pieces of the beef tips au jus. Based on visual observation, the residents received approximately 1 ounce of beef tips au jus. A standard serving size for 3 ounces of meat equals the size of a standard deck of playing cards. A white notebook located on the top of the refrigerator contained the daily menus and what serving utensils to use on each food to ensure residents received the correct serving size. During the observation of the lunch meal on 3/29/12 at 11:15 a.m., the white notebook was not out and had not been reviewed by LPN #1. LPN #1 was interviewed on 3/30/12 at 8:56 a.m. During the interview he indicated serving utensils used to plate food to the residents on the Memory Care unit was based on habit. The Certified Dietary Manager (CDM)		spread sheet is located in a white binder on the Memory Care Unit. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** An all staff in-service will be conducted. The in-service will include review of facility policies titled, "Portion Sizes" and "Standard Portions". Further more the in-service will include review the therapeutic spread sheets and proper food service techniques. The in-service will be conducted by the Dietary Manager and/or designee. **How will the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place:** To ensure ongoing compliance with this corrective action, the Dietary Manager and/or designee will conduct an audit that would include proper portion sizes, recommended food temperature, following the therapeutic spread sheet and food storage guidelines. This audit will be conducted daily x 3 weeks, then 3 times a week for 3 weeks, then one time a week for 3 weeks and then monthly thereafter. Findings will be submitted to the QA & A committee for review and follow up. **By what date the systemic changes will be completed:** Compliance Date = 04/29/2012 **Addendum Request: Findings will**	

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	155567	A. BUILDING 00 B. WING	03/30/2012

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	was interviewed on 3/30/12 at 9:36 a.m. During the interview she indicated the kitchen provides the necessary serving utensils required for each meal in the Memory Care unit. She also indicated there was a white notebook in the Memory Care unit which contained the daily menus and what servings utensils were to be used on each food. She further indicated the notebook was to be used as a reference for staff and the tongs were not the correct serving utensil for the beef tips au jus. A current facility policy "Portion Sizes", dated 2008 and provided by the CDM on 3/30/12 at 11:05 a.m., indicated "...The menu adopted by the facility will illustrate portion sizes for each diet to meet the nutritional standards as set forth in the facility's diet manual and to meet the most current DRI's (Dietary Reference Intakes)..." A current facility policy "Standard Portions", dated 2008 and provided by the CDM on 3/30/12 at 11:05 a.m., indicated "...Portion sizes are written on the menu to ensure equal portions are served to provide adequate nutritional care. Follow portion sizes to be served as directed by the menu...Standard portion control		**be submitted to the QA & A committee for review and follow up times 6 months with a subsequent plan developed and implemented as necessary.**	

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	utensils will be used...." The 2011 Indiana Diet Manual indicated "...A diet should provide all the nutrients and energy in appropriate amounts for each person...A diet should be adequate at all times...Nutrition adequacy of diets must follow general standards and guidelines such as...The Dietary Reference Intakes...The U.S. Dietary Guidelines...." 3.1-20(i)(1)			

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F0364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. Based on observation, interview and record review, the facility failed to provide a nutritionally adequate meal to 18 of 19 residents (Residents #74, #64, #70, #24, #7, #39, #85, #26, #40, #76, #17, #41, #73, #107, #34, #95, #75, and #80) who reside in the Memory Care Unit. Findings include: 1. During an observation of the breakfast meal on 3/26/12 at 7:00 a.m., Residents #74, #64, #70, #24, #7, #39, #85, #26, #40, #76, #17, #41, #73, #107, #34, #95, and #80 were seated in the Memory Care dining room waiting for breakfast. Steam table pans of food were delivered to the unit from the facility kitchen. The steam table pans of food were placed into the wells of the portable dry warming units. The steam table pans of food remained in the wells until 7:15 a.m., when LPN #3 was observed to take the temperatures of the scrambled eggs and the hot cereal. The scrambled	F0364	**F 364 – Nutritive value/Appear platable/Preferred Temperature** It is the practice of this provider that each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is platable, attractive, and at the proper temperature. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Residents 74,64,70,24,7,39,85,26,40,76,17,41, 73,107,34,95,75, and 80 did not experience any negative outcome as result of this finding. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** The identified staff members,LPN 3 no longer works for the facility and LPN 1 was thoroughly in-serviced/re-educated regarding food temperatures at the point of service and what action should be taken if food is not at the recommended temperature. As well as recording the food temperature	04/29/2012

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	eggs registered at 102 degrees and the hot cereal registered at 100 degrees. LPN #3 was observed to immediately serve the scrambled eggs and the oatmeal. No attempt was made to contact the kitchen for replacement food items at the appropriate temperature and no attempt was made to re-heat the food items in the kitchen area on the Memory Care unit. There were no food temperatures recorded for the breakfast meal on 3/26/12 in the Food Temperature Log. 2. During an observation of the lunch meal on 3/29/12 at 11:00 a.m., Residents #74, #64, #70, #24, #7, #39, #85, #26, #40, #76, #17, #41, #73, #107, #34, #95, and #80 were seated in the Memory Care dining room waiting for lunch. Steam table pans of food had just been delivered to the unit from the facility kitchen. The steam table pans of food were placed into the wells of the portable dry warming units at 11:12 a.m. by LPN #1. LPN #1 was observed to attempt to take the temperatures of the hot food with a digital thermometer designed for use on humans. After realizing the thermometer would not be able to read the high temperatures of hot food, he wiped the thermometer clean		for all 3 meals in the Food Temperature Log and using a food thermometer provided by the Dietary Department. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** An all staff in-service will be conducted. The in-service will include review of the facility policy titled, "Food Service Temperature Control", recording of food temperature for all 3 meals, and what action should be taken if food is not at the recommended temperature. The in-service will be conducted by the Dietary Manager and/or designee. **How will the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place:** To ensure ongoing compliance with this corrective action, the Dietary Manager and/or designee will conduct an audit that would include proper portion sizes, recommended food temperature, following the therapeutic spread sheet and food storage guidelines. This audit will be conducted daily x 3 weeks, then 3 times a week for 3 weeks, then one time a week for 3 weeks and then monthly thereafter. Findings will be submitted to the QA & A committee for review and follow up. **By what date the systemic changes**	

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	and placed it back into the medicine cart. Provided with a food thermometer by another staff on the Memory Care unit, LPN #1 was observed to take the temperatures of the hot food at 11:15 a.m. Review of the Food Temperature Log for the lunch meal on 3/29/12 indicated the following: beef tip au jus - 176 degrees, buttered noodles - 172 degrees, and the Italian blend vegetables - 160 degrees. There were no food temperatures recorded for the alternate food choices of chicken breasts and seasoned rice for the lunch meal on 3/29/12. During the observation of the lunch meal in the Memory Care dining room on 3/29/12 at 11:00 a.m., the dry portable warming units, designed to keep the steam table pans of food at the appropriate temperature, were not plugged in during the meal service. At 11:30 a.m.,immediately following food served to the last resident in the Memory Care dining room, the following temperatures of the hot food were obtained: chicken breasts - 100 degrees, seasoned rice - 99 degrees, Italian blend vegetables - 90 degrees, and beef tips au jus - 120 degrees. LPN #1 was interviewed on 3/29/12 at 2:40 p.m. During the interview he		**will be completed:** Compliance Date = 04/29/2012 **Addendum Request: Findings will be submitted to the QA & A committee for review and follow up times 6 months with a subsequent plan developed and implemented as necessary.**	

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	indicated he was not sure what to do if the temperatures of the hot food were low. He also indicated the dry portable warming units should have been plugged in. The Certified Dietary Manager (CDM) was interviewed on 3/30/12 at 9:36 a.m. During the interview she indicated food for the Memory Care unit was prepared and dished into steam table pans in the facility kitchen. Temperatures of the food were taken and then the food was transported to the unit. She also indicated portable dry warming units were used in the unit to keep the steam table pans of food at the appropriate temperature and were to be plugged in during the meal service. She further indicated temperatures of the food were to be taken before the food was served to the residents. A food thermometer was kept in the Memory Care unit kitchen area and the temperatures were to be recorded in the Food Temperature Log. She also indicated the facility kitchen was to be contacted if the food was not at the appropriate temperature at the time of service. Facility directions for "Taking Food Temperatures", dated 3/24/10 and located in the Food Temperature Log			

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	on the Memory Care unit, included, but were not limited to, food temperature must be checked with each meal, temperatures of hot food must be 160 degrees at the time of service, check food temperature with the thermometer provided, check each hot food dish and record temperature on log, and check temperatures before serving first person. A facility policy "Food Service Temperature Control", dated 2008 and provided by the CDM on 3/30/12 at 11:05 a.m., indicated "...Using a calibrated food thermometer, obtain final temperatures for all menu items, hot and cold, prior to serving...Any food not meeting minimum temperature requirements will be brought to the proper temperature prior to serving...." 3.1-21(a)(2)			

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F0371 SS=A	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview and review of facility documents the facility failed to date food in 1 of 4 refrigerators. Finding includes: **During the environmental tour on 3/28/12 at 2:10 p.m. observation of the refrigerator on the memory care unit indicated 5 individual serving bowls of peaches in the refrigerator which were covered with clear wrap but undated.** **Interview with the activity staff person indicated the peaches had been left over from the noon meal.** **On 3/30/12 at 1:30 p.m. review of the facility policy, which was undated, indicated leftover food was to be labeled and dated.** **3.1-21(i)(2)**	F0371	**F - 371 Food procure, store/prepare/serve - Sanitary** It is the practice of this provider that procures food from sources approved or considered satisfactory by Federal, State or local authorities; and store, prepare, distribute and serve food under sanitary conditions. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** No residents were found to be affected by this alleged deficient practice. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** The identified staff member will be in-serviced/re-educated to facility policy related to labeled and dated food. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** An all staff mandatory in-service will be conducted. The in-service will	04/29/2012

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			include review of the facility policy titled, "Left Overs". **How will the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place:** To ensure ongoing compliance with this corrective action, the Dietary Manager and/or designee will conduct an audit that would include proper portion sizes, recommended food temperature, following the therapeutic spread sheet and food storage guidelines. This audit will be conducted daily x 3 weeks, then 3 times a week for 3 weeks, then one time a week for 3 weeks and then monthly thereafter. Findings will be submitted to the QA & A committee for review and follow up. **By what date the systemic changes will be completed:** Compliance Date = 04/29/2012 **Addendum Request: Findings will be submitted to the QA & A committee for review and follow up times 6 months with a subsequent plan developed and implemented as necessary.**	

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F0441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, interview and record review, the facility failed to	F0441	**F 441 – Infection control, Prevent Spread, Linens** It is the	04/29/2012

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	ensure 1 of 4 nurses who were observed during medication administration washed and/or sanitized their hands for 3 of 11 residents observed during medication administration.(Residents #26, #39 and #40) Finding includes: On 3/29/12 at 8:30 a.m. observation of nurse # 1 indicated he was passing medications to residents. The nurse prepared and administered medications for residents #26, #39 and #40. During the administration of the medications the nurse touched the inside of the administration cups after the residents had put the cup to their mouths. The nurse was also observed to touch the resident's clothing, wheelchairs, bedside tables and inhalers. Nurse #1 did not wash his hands, and only used sanitizer after administering the medications to the 3 residents. On 3/29/12 at 9:20 a.m. interview with nurse #1 indicated he only washes his hands during medication pass if he touches a resident. On 3/29/12 at 1:00 p.m. review of the		practice of this provider to establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Residents 26, 39, 40 did not experience any negative outcome as a result of this alleged finding.**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by this finding. The identified staff member, Nurse 1, will be thoroughly in-serviced/re-educated on proper Medication Administration practices and hand washing practices during Medication Administration. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** An all nursing staff in-service will be conducted. The in-service will include review of the facility policy titled, “Medication Administration” and hand washing practices during Medication Administration. The DON/DSD and/or designee	

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	facility policy for "Medication Administration", which was undated, indicated hands were to be washed or use hand sanitizer when touching a resident or assisting a resident to take medications. 3.1-18(l)		will be responsible for conducting the scheduled in-service. **How will the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place:** Each nurse will complete a check-off/return demonstration on medication administration including hand washing techniques. Any observed concerns noted during check-offs will be addressed and corrected immediately. The DON and/or designee will responsible for completion of return demonstration skills check off. Three Medication Administration observations will be completed weekly for one month and then monthly for four months. Medication Administration observations will be conducted on varying shifts. Any findings will be reported to QA & A committee for review and follow up. **By what date the systemic changes will be completed:** Compliance Date = 04/29/2012**Addendum Request: Findings will be submitted to the QA & A committee for review and follow up times 6 months with a subsequent plan developed and implemented as necessary.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155567	A. BUILDING 00 B. WING	03/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSITY PARK HEALTH AND REHABILITATION CENTER	1400 MEDICAL PARK DR FORT WAYNE, IN 46825

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. Based on record review and interview, the facility failed to ensure the facility's Quality Assessment and Assurance (QAA) committee identified concerns regarding serving nutritionally adequate food portions, serving food at the correct temperature, and the dating of food stored in the refrigerator on the memory care unit, potentially affecting 18 of 19 residents who lived on the memory care unit (Residents #74,	F0520	**F 520 – QA&Committee-Members/Meet Quarterly/Plans** It is the practice of this provider that a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Residents 74,	04/29/2012

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	#64, #70, #24, #7, #39, #85, #26, #40, #76, #17, #41, #73, #107, #34, #95, #75, and #80 Finding includes: The facility's Executive Director (ED) was interviewed on 3/30/2012 at 11:45 A.M. During the interview, the ED indicated the facility had a QAA committee that met quarterly to identify and correct quality concerns. During the interview, the ED indicated the QAA had not identified any concerns on the memory care unit regarding food service and food storage on the memory care unit. A facility policy titled "Quality Management Program", dated January 2012, indicated "it is a policy that a functional Quality Management Program is maintained to monitor and evaluate the quality of resident care services, pursue methods to improve quality and all areas of organizational functioning, and to promote safety by using a systemic problem identification and resolution process. See F 363 regarding: Based on observation, interview and record review, the facility failed to provide a nutritionally adequate meal to 18 of 19 residents (Residents #74, #64,		64,70,24,7,39,85,26,40,76,17,41, 73,107,34,95,75 and 80 did not experience any negative outcome as a result of this finding.**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** Residents residing on the Memory Care have the potential to be affected by this alleged finding.**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** An all staff in-service will be conducted. The in-service will include the facility policies titled, “Left-Overs”, “Food Temperature Control”, “Portion Sizes”, and “Standard Portions”. In addition, the in-service will include the facility practice as it related to the dining service on the Memory Care Unit. The in-service will be conducted by the Dietary Manager/designee. **How will the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place:** To ensure ongoing compliance with this corrective action, the Executive Director/designee will complete a QA&A audit titled, “Memory Care Center Review”. The Audit will be completed monthly and results will be reviewed by the QA&A	

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	#70, #24, #7, #39, #85, #26, #40, #76, #17, #41, #73, #107, #34, #95, #75, and #80) who reside in the Memory Care Unit. See F 364 regarding: Based on observation, interview and record review, the facility failed to provide a nutritionally adequate meal to 18 of 19 residents (Residents #74, #64, #70, #24, #7, #39, #85, #26, #40, #76, #17, #41, #73, #107, #34, #95, #75, and #80) who reside in the Memory Care Unit. See F 371 regarding: Based on observation, interview and review of facility documents the facility failed to date food in 1 of 4 refrigerators. 3.1-52(b)(1)		committee with actions plans developed as needed. **By what date the systemic changes will be completed:** Compliance Date = 04/29/2012**Addendum Request: Findings will be submitted to the QA & A committee for review and follow up times 6 months with a subsequent plan developed and implemented as necessary.**	